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ABSTRACT

The booklet is intended to provide an overview of Tourette Syndrome, (TS), a neurological movement disorder characterized by multiple involuntary tics, uncontrollable vocalizations, and a range of behavior problems including attention deficit and hyperactivity. Typical characteristics of TS are described along with information on etiology, diagnosis, and treatment. Among educational implications considered are the incidence of learning disabilities and common problems of attention, handwriting difficulties, and the compounding difficulties of stress. Case studies illustrate management of TS individuals in school and in the workplace (through vocational rehabilitation). Special considerations for institutionalized, mentally retarded and autistic, as well as normal intelligence individuals with TS are examined. Implications for mental health practitioners are discussed in terms of counseling needs for the individual and family. (CL)

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INTRODUCTION

This booklet is designed for use by a wide variety of service providers and professionals who are interested in addressing the needs of persons who have the handicapping neurological movement disorder, Tourette Syndrome (TS). The needs of people with TS will vary from client to client and may change, like the symptoms of TS itself, over an extended period of time.

Since TS symptoms wax and wane throughout life, a client's needs may be intense and immediate for some time. Then, unpredictably, the motor and vocal symptoms may improve somewhat. Behavior may also become more manageable until the client again enters a period of exacerbation.

As a service provider you are probably involved with a program that serves many people with various types of disabilities. It is important to remember that the needs of people with TS are unique compared to other clients with more familiar disabilities. TS should be fully understood before attempting to address the needs of a client with this condition.

Services needed by individuals with TS can range from none at all, to special education or school program modifications, to vocational rehabilitation, residential programs or life-long case management services. The need for each service can often be measured according to the degree to which TS interferes with a person's life, and not solely by severity of motor and vocal symptoms.

Many people with TS cope successfully and live independent, productive lives. However, at times even those with minor Tourette related problems may require some services or interventions of a temporary nature; i.e., a simple accommodation at their place of employment, intervention with a landlord or neighbor, or someone to explain to those in authority that the client's motor and vocal symptoms are *NOT* purposeful and are *NOT* meant to be disruptive.

If you have specific questions about your client which are not answered in this manual, please feel free to contact:

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I. THE DISORDER

Tourette Syndrome (TS) is a neurological multiple tic disorder which begins between the ages of 2 and 16 and lasts throughout life. The symptoms of this *developmental disability* follow a waxing and waning course. TS is not degenerative or fatal.

A. Symptoms

1. Motor Symptoms:

TS is characterized by multiple involuntary tic movements, the most common being rapid eye blinking, shoulder shrugging, facial twitches, head, arm or leg jerking. These repetitive muscular movements are commonly misinterpreted as "nervous habits" or a behavioral abnormality. TS tics and twitches always get worse under stress; they may lessen or disappear for short periods of time during non-anxious focused attention to a task or activity.

2. Vocal Symptoms:

Motor symptoms are combined with uncontrollable vocalizations such as repeated throat clearing, grunting, sniffing or hissing. These symptoms can also be misinterpreted as a "nervous cough" or "bad habits." In more severe cases vocalizations can be quite loud and disturbing such as shrieking, barking, and/or abrupt outbursts of sounds or words. In 30% of cases people with TS will get coprolalia, which is involuntary outbursts of obscene words. Other speech problems can occur including echolalia (repeating the words of others), palilalia (repeating one's own words), stuttering, speaking in uneven rhythms, accenting syllables, etc.

3. Behavioral Symptoms:

Behaviors commonly associated with TS may include attention deficit, hyperactivity, impulsivity, learning disabilities, imitating movements and gestures of other people, and/or obsessive-compulsive or ritualistic behaviors.

Compulsive behaviors may include touching or rubbing objects, checking repeatedly to see if doors are locked or if the stove is turned off, ripping, breaking or hitting objects, etc. In the most severe cases, self-mutilating symptoms may occur including head banging, biting or hitting oneself.

Examples of ritualistic behaviors may include compulsively walking through doorways with a specific foot first, jumping, hopping, touching the floor, having to arrange and rearrange objects in a specific manner, etc. These can be the most crippling behavioral symptoms of TS because they consume so much time.

B. Etiology

TS is caused by a chemical imbalance in the brain. The disorder appears to be genetic in 50% to 70% of cases. In these families one or more relatives have been identified with either milder tic conditions or Tourette Syndrome. This would indicate that mild tic conditions are probably a genetic continuum of one disorder, and TS is the most severe end of that spectrum.

A growing number of children have been identified with stimulant induced TS. That is, stimulant medications commonly prescribed to hyperactive children (i.e., Ritalin, Cylert, Dexedrine, etc.), can sometimes precipitate TS in predisposed children, according to the Food & Drug Administration (FDA).

C. Diagnosis

Many persons with TS are misdiagnosed for a lengthy period of time due to professional unfamiliarity with the syndrome. Commonly, families have brought a child to a wide variety of professionals during their search for a diagnosis. Clients may be told that their symptoms are caused by psychological factors and will often be referred to mental health practitioners. Often they are wrongly advised that the symptoms are "nervous habits" which will disappear eventually, or they are misdiagnosed with a variety of ailments. As a result, some people with TS have been treated with ineffective and even dangerous therapies. The correct and/or confirming diagnosis and treatment plan should be made by a neurologist, psychiatrist or neuropharmacologist familiar with diagnosis and treatment of Tourette Syndrome.

D. Treatments

The only proven effective treatments for Tourette Syndrome are pharmacological. Most often used medications include neuroleptics such as haloperidol (Haldol), pimozide (Orap), fluphenazine (Prolixin), and clonidine (Catapres) which is an anti-hypertensive medication. Information about each of these medications is available through the Tourette Syndrome Association.

It is important to consider side effects of any therapeutic agent when dealing with a client who has TS. Some medications can cause severe depression, short-term memory problems, cognitive interferences, etc.

Psychotherapy is not an effective treatment for the symptoms of TS. However, it can be very helpful in assisting TS clients to adjust to, understand, and cope with the effects of Tourette Syndrome. The need for assistance with this adjustment cannot be minimized.

E. Implications

The motor, vocal and behavioral symptoms of TS can be quite disturbing to the TS client, his/her family, and society in general. TS symptoms are often perceived as bizarre and frightening. The years during which a client is undiagnosed or misdiagnosed can have a lasting psychological impact. The client may have been punished by family, rejected by teachers, teased by peers and looked upon as a disruptive or emotionally disturbed child. Significant persons in the child's life may have insisted that he/she *could* stop the symptoms if the child really wanted to. It is not surprising that the undiagnosed person with TS often begins to question his own sanity. However, studies have shown that the severity of a TS client's motor and vocal symptoms are not the predictors of satisfactory or unsatisfactory adjustment. Rather, the behavioral handicaps, degree of family support, effectiveness of medication, educational level, intelligence, etc., can help or hinder a person's later independence and productivity. Some people with very severe motor and vocal symptoms have succeeded in all areas of life and even pursued professional careers which exceed the goals of people without disabilities. Others, with only minor motor and vocal symptoms can be severely disabled by their behavioral symptoms and/or emotional maladjustment.

There is no set formula which draws a line between the difficulties a person with TS faces in his lifetime as a result of having the disorder, the implications of misdiagnosis, and those behaviors which are a part of the syndrome itself. "Where does the Tourette Syndrome end, and the person begin?", is a question often asked by service providers who are dealing with a TS client. Like most neurological impairments, this answer is not yet clear.

F. Important TS Characteristics

People with TS can postpone or substitute symptoms for a variable period of time. Implications of this characteristic may be both positive and negative:

1. People with TS tend to hold back their symptoms when in the presence of strangers. Thus, one reason TS is often not properly diagnosed is because the person may not display symptoms in the doctor's office. It is important that the diagnosing physician schedule a lengthy initial office visit. If symptoms do not appear after some time has passed, the person with TS should be asked to sit in a place where he is unaware that he's being observed (i.e., a waiting room). At that time the symptoms will probably be expressed.

2. While symptoms are being postponed, much energy and concentration must be used to hold them back. At those times, the client is usually not listen-

ing to speakers, teachers, etc., and performance can be impaired. In a learning situation, it is better to allow the symptoms to be expressed.

3. Symptoms will be expressed more explosively after they have been held back. Therefore, persons with TS should be given a "safe place" to go where they may release their symptoms without disturbing others. In school this can be an empty classroom, nurse's office, etc. At a place of employment, a nearby restroom or an office providing privacy might be used.

4. The great majority of people with TS can drive cars and work with various equipment. They do not lose consciousness during their tics. Since they can postpone or substitute symptoms for varying periods of time (according to the severity of the case), they are usually able to do precise work without their motor movements interfering. As soon as a task is finished, they may have to express more intense repetitive movements in order to compensate for the postponement of motor activity. Therefore, they may require extra time to complete a task.

5. The compulsive component of TS can sometimes work to the client's advantage. Many people with TS feel that they must do things perfectly. As a result they can be excellent workers because they will settle for nothing less than a job well done. This characteristic, if it does not become too time-consuming or ritualistic, can be one of the client's greatest assets.

6. People with TS have the same range of intelligence characteristic of the general population. A few cases of mentally retarded people with TS have been reported, while the remainder have average to above-average intelligence.

II. EDUCATION

The educational implications of TS are complicated because of the variable degree of social factors, learning disabilities, cognitive impairments caused by medications (or occurring naturally), teacher unwillingness to accept TS symptoms, the degree of motor and vocal control, and the effects of psychological stress.

Tourette Syndrome is a handicapping condition under Federal Law, the "Education for All Handicapped Children Act" (PL94-142). Children with this neurological impairment are eligible for special education and related services. Sixty percent of children with TS have identifiable learning disabilities which can intensify their difficulties in the classroom.

Learning disabilities associated with TS often involve mathematics and/or certain areas involving language. Sometimes math problems actually involve handwriting difficulties such as not writing

numbers in the correct column, placing decimal points in the incorrect place, etc. Language difficulties can involve both the understanding of language and language production. These difficulties usually don't become apparent until the upper grades when the child is expected to comprehend more complicated vocabulary and sentences.

The most common problem faced by students with TS involves their basic responsibility to sit still, pay attention and be quiet. Because they are not always capable of doing this they must be allowed some freedom of movement and not be reprimanded for being fidgety, taking too many trips to the lavatory, etc. Attention Deficit Disorder (ADD) is a common component of TS, and the student may often need to be guided back to the task by teachers.

Another common problem involves handwriting difficulties. Handwriting may be sloppy or illegible. People with TS may have great difficulty forming letters, they may compulsively tear paper, put dots in places where they don't belong, or go over and over letters. In those cases where handwriting does not appear to be sloppy, we often hear that the "perfectionist" compulsive behaviors which make the child write neatly (and if it's not neat enough, the child will do it over and over again) take extensive periods of time. Children with TS generally find it difficult to copy notes from a blackboard and may require handwritten notes on a piece of paper so that they do not have to focus from a near to far distance repeatedly.

The writing problem is also impacted by the psychological effects of stress. Stress always makes tics worse, and time limits are a common source of stress to TS students. In these cases tests should be given without time limits, and sometimes in a separate quiet room. At times substitutes for writing must be offered; the child can be given a tape recorder or allowed to dictate answers to another person; written notes can be given to the student by a classmate who has used carbon paper while taking notes.

Behaviors can also cause educational problems. The child may be perceived as hyperactive and/or a discipline problem because he/she disturbs classmates, calls out in class, touches other people, etc. These behaviors do indeed represent a problem for a classroom teacher. However, proper diagnosis, medication (when indicated), appropriate adjustment to the child's program and/or psychotherapy might be appropriate interventions according to the individual circumstances.

Case Study 1

A child who made loud noises every 15 to 20 minutes may have seemed to be a good candidate for medication. However, his physician requested that the child be allowed out of the room every 20 minutes so he could discharge his symptoms away from the classroom. The child no longer disturbed his classmates and was no longer considered a discipline problem.

Case Study 2

Tommy was a very active baby. When he started nursery school the teacher told his mother that he did not pay attention to tasks requiring sustained activity. In kindergarten, Tommy began to exhibit tics and twitches - rapid eye blinking, facial twitches, repeated throat clearing, and grunting. The teacher felt these disruptive behaviors were "nervous habits," and she reprimanded Tommy often. Tommy's mother also felt that he could sit still and be quiet if he'd only try. The family pediatrician told Tommy's parents that tics are very common during childhood and that they would soon disappear if the family would ignore them.

By the time he entered fourth grade, Tommy was considered a behavioral problem by his family, teachers, and classmates. Although he often tried to inhibit his tics and vocalizations, he found that they simply had to be expressed and that they were even more explosive if he postponed them. His family, teachers, and classmates seemed always to be upset with him. Everybody told him he was capable of controlling symptoms which he knew were uncontrollable.

Tommy's school work was sloppy and disorganized, but his performance was not significantly below grade level. He had not been referred for a special education evaluation because his teachers felt he could do better if he'd only try harder.

Tommy was lonely, hurt by other people's reactions to him, and at risk of becoming emotionally disturbed when the school nurse suggested to his mother that Tommy might have Tourette Syndrome. After diagnosis, Tommy responded well to medication. Through an Individual Education Plan (IEP) he was provided with academic assistance and counseling services which significantly improved his school performance and social skills.

III. VOCATIONAL REHABILITATION

The TS adult who seeks vocational training will require a complete analysis of cognitive functioning, emotional adjustment, vocational aptitudes and a

creative approach to circumventing problems related to motor, vocal and behavioral symptoms. A rehabilitation counselor should not assume that any one intervention (such as medication) will solve all of the client's problems.

A natural reaction to seeing a person with severe TS symptoms might lead to the conclusion that the client would be best employed in a socially isolated position. However, this is not always the case. So many people with TS have been isolated and rejected by peers throughout their lives that they consider social contact as a primary reward of employment. If the client's symptoms would be very disturbing to co-workers, the vocational counselor must consider use of sound-absorbing materials at the client's workplace, or perhaps placement in a noisy environment such as a factory where vocalizations will not be noticed. Other people with TS may not desire social contact and isolated work (such as a night watchman) might be appropriate.

Sometimes people with TS feel they can conceal symptoms from others. Unfortunately, this eventually may lead to a crisis when other employees begin to notice the client's tics and misinterpret them as bizarre behavior. At that time it may be too late for remedial action. It is therefore important that coworkers and supervisors be advised about the symptoms of TS, with the permission of the client.

Case Study 3:

A 57 year-old unemployed dishwasher was diagnosed as having Tourette Syndrome after 53 years of symptoms. When he learned that he was now eligible for services available to other disabled people, he sought vocational rehabilitation. The VR counselor performed a complete evaluation and determined that the client would do well at a typesetting job because he was an avid reader and excelled in areas involving language and manual dexterity. Also, typesetting machines are relatively noisy which would minimize distractions caused by the client's vocalizations.

During the first three months of training, maintenance of the machine was taught. The following nine months were spent on actual typesetting jobs. Ten months into the program the VR counselor reported that the client was an excellent worker who loved typesetting and was particularly suited for the job. However, for an unknown reason, the client had forgotten everything he learned about machine maintenance during the first three months.

After an investigation it was learned that the client had been medicated with haloperidol during the first three months of training. Sensing that it had "clouded" his mind, he discontinued the medication during the

fourth month of training. One possible side effect of haloperidol includes blunting of short-term memory, so everything he had learned during the beginning of the course had to be taught to him again. He his now successfully employed.

Case Study 4:

A brilliant young man with TS entered a special college program with the help of Vocational Rehabilitation services. He could not keep his head steady enough to read, so he used recorded books. Teachers gave him written notes and he used a tape recorder for oral rather than written reports.

The student had a great deal of difficulty studying in his dorm and using the library. His vocalizations disturbed other people. The VR agency arranged to construct a soundproof booth in the library for the TS student so he could study without disturbing others. In addition, untimed tests were given in a separate room. The student graduated with a 3.9 average and went on to graduate school.

IV. DEVELOPMENTAL DISABILITIES

DD Caseworkers and personnel will be handling more and more TS clients as time proceeds. Under the redefinition of Developmental Disabilities, people with TS who have all ranges of intelligence are eligible for services.

A. The Institutionalized Client

Some people with TS have been institutionalized as a result of misdiagnosis and bizarre behaviors. Today, more and more physicians are beginning to recognize the syndrome and proper diagnosis is being offered earlier during developmental years. Even so, some people with TS will require a closely supervised setting such as a psychiatric facility because their behaviors are so disruptive and frightening, or because of other concurrent psychiatric disorders.

Medications for treatment of TS do not work at all on some people, and in other cases side effects may be intolerable. If the prime goal for the institutionalized client is deinstitutionalization, many interventions may be needed until such time as the client can inhibit behaviors which he/she knows are socially unacceptable.

It is important for all personnel who are exposed to a severe TS client to fully understand the nature of the disorder. It is counter-productive to punish a TS client for saying obscene words when coprolalia is a symptom of his/her illness. Similarly, one should not say to a TS client, "you cannot participate in this

group activity unless you quiet down." The nature of the syndrome is such that the more a TS client tries to sit still and be quiet, the more he is unable to do so *(See Section IV for Mental Health Practitioners).*

Persons with TS cannot stop their symptoms completely and indefinitely. However, some clients can learn to substitute one socially unacceptable symptom with a less obtrusive symptom. For example, a client may compulsively touch other people causing negative social interactions. It can be suggested, since the client knows how devastating this symptom can be, that he find a substitute symptom which would allow him to touch walls, objects, or himself, rather than other people. He may find that patting his own knee 4 or 5 times will be equivalent to touching another person once. If this type of symptom substitution works for one symptom, it may work for others. On the other hand, some client's symptoms may be so out of control that they are unable to substitute at all. These clients should not be made to feel guilty for their inability to suppress or substitute symptoms.

B. Mentally Retarded and Autistic Clients

Persons with TS who are mentally retarded or autistic are commonly misdiagnosed for extensive periods of time because their behaviors are often interpreted to be a component of their retardation. Since repetitive and ritualistic patterns of behavior are often a component of retardation, it is important that service providers recognize the symptoms of TS when they occur in this population because many of these MR/TS clients will respond to medication.

A number of reported cases involve people who were diagnosed as mentally retarded as youngsters, but as adults retested as borderline to normal IQ. Review of records indicates that these people most often had severe Attention Deficit Disorder and learning disabilities with hyperactivity. Having been educated in schools with retarded people, they learned to imitate the behaviors of their peers. It would be important to learn, when investigating cases such as these, if the client was ever prescribed stimulant medications such as Ritalin, Cylert, Dexedrine, etc. *Stimulant medications can precipitate Tourette Syndrome in children who are genetically predisposed to TS.*

The Food & Drug Administration sent a "Physician's Drug Alert" to all doctors in 1982 warning them about this problem, and labeling on these products has been changed to include that warning. However, many clients are still being identified with the onset of TS during stimulant therapy.

Case Study 5:

Diane was diagnosed as mentally retarded when she entered school. Since her development was unusually slow, her tics, twitches, and minor vocaliza-

tions such as sniffing and throat clearing were considered to be related to her retardation. Her parents, who spoke little English, were unable to converse with doctors, teachers, and service providers. As a result they were unable to express their deep concern over the intensity of Diane's symptoms at home where they were more pronounced than in school.

At the age of 21, Diane was re-evaluated for a vocational program. The evaluators realized that she actually had a borderline IQ and could perform normally in several crucial areas. Members of the evaluation team noticed Diane's involuntary movements and vocalizations when she was under stress, and they referred her for a neurological examination, which revealed that Diane had Tourette Syndrome.

Diane was given medication that reduced the frequency and volume of her tics. With training at a sheltered workshop she became employable.

C. Clients of Normal Intelligence

Persons with TS who have average to above-average intelligence may pose a problem to the DD caseworker who recognizes that placement with mentally retarded clients may not be appropriate. The services these clients may need include psychotherapy, family supports, residential placement (in a school or community residence), sheltered workshops, VR training, employment, etc., according to individual need and symptomatology.

For the most part, adults with TS in need of DD services will be found living with their parents in the community simply because they have few other options. If they are still dependent they may not be aware that TS is considered a disability and that they are eligible for services and benefits enjoyed by other disabled people.

These clients may need assistance applying for Social Security and other benefits. They may not be aware of the availability of Vocational Rehabilitation services. In some instances they will have been reclusive for many years and unable to take public transportation because of the reactions they may elicit from the public. For example, if they have coprolalia, they may have been harrassed by the police or even beaten by strangers who thought the client was cursing at them.

Many of these adults will not have completed their education. If they had severe but undiagnosed TS during their high school years, they may have been expelled from school (or dropped out) as a result of their behavior. One young adult reported that he had been tied to a chair and gagged by a high school teacher who was absolutely positive that the embarrassment would force him to be quiet. As a result, he left school as soon as he became 16, causing a major negative impact upon his subsequent employment options.

Today, since many people with TS are obtaining proper diagnosis at a younger age, the caseworker is able to offer important interventions at critical times. Classification as a handicapped child during school years may offer much needed supportive services. Service providers should also be aware that puberty is usually the worst time for TS symptoms, and common difficulties faced by all teenagers can be significantly magnified when one has TS.

If you are involved with a TS client and family you should contact the Tourette Syndrome Association for a geographic listing of physicians in your area who specialize in the diagnosis and treatment of TS; listings of TSA chapters which provide self-help support groups; literature specifically designed to answer the most commonly asked questions of teachers, parents, TS clients, doctors, counselors, etc. In addition, video tapes are available for training.

V. MENTAL HEALTH PRACTITIONERS

Counseling for TS clients and their families can be a complicated matter because it is often difficult to differentiate between behaviors that are symptoms of TS and those that are not.

Families of newly diagnosed children often face a grieving process similar to that of other families who receive a diagnosis of any chronic disabling condition. Some parents of children with TS may feel exceptionally guilty because of the unfortunate actions that result from the long period between onset of TS and proper diagnosis. These may include the use of ineffective and even dangerous therapies which may have been suggested by several professionals, punishment of the child for symptoms the parents believed were controllable, and genetic questions, especially if another relative has tics.

Sometimes one parent may have a more difficult or lengthy period of adjustment than his/her spouse. It is always valuable to schedule face-to-face meetings with parents in order to determine the best treatment plan for the client and family. When the child with TS senses the parents' concern, he/she may become manipulative. Parents must recognize that their child is not "sick," and should join in normal life activities (including chores) as much as possible.

Control is a key issue. As symptoms wax and wane, many families feel that periods of exacerbation represent a loss of control. Some physicians, knowing that a patient will be taking medication for years, will allow a parent to raise and lower the dose according to severity of symptoms at any particular time. Unfortunately, some parents hope to cover up *all* TS symptoms to make their child "better," and those children may become over-medicated. It is important to let parents know that no medication will take away *all* TS symptoms, and that many coping strategies are needed

beyond the use of medication. In any case, all TS clients taking medication should be seen by their TS physician at least once each year or more often if medication is titrated.

TS symptoms may be very mild during social activities because the child will try to substitute or delay symptoms in order to avoid being teased by peers. When this occurs symptoms will often appear to be non-stop and explosive when the child returns home. Parents must be taught that the child with TS will let out all his/her pent up tics when in a "safe place," and home is where a "safe place" should be. Thus, the severity of tics which parents see at home, where a child is comfortable and at ease, is usually more intense than those that occur outside the home. Parents should view this phenomena as positive, rather than negative, and should minimize the importance of tics at home.

The behavioral aspects of TS are also problematical. Besides the compulsive and ritualistic behaviors which plague some people with TS, some clients might exhibit poor impulse control, temper outbursts, oppositional behaviors, etc. Research on these problems is underway because scientists are trying to determine if they occur only in conjunction with Attention Deficit Disorder (ADD) or in a broader spectrum of TS patients.

Current knowledge about TS related behavioral problems theorizes that TS seems to involve a dysfunction of the inhibitory system. Thus, people with TS sometimes find it very difficult to inhibit their impulses to move, make sounds, or act in a certain manner. Sometimes asking a person with TS to stop doing something will only make him do it more.

Behavioral problems can be manifested in many ways. At times it may appear that a client is exhibiting symptoms on purpose just to get attention. For example, he/she may not have vocalizations for several hours, but when the client walks into a quiet library he/she may erupt with loud noises. This is not purposeful behavior. One must realize that any person, when they go into a library, will become conscious of the expectation to be quiet. When the person with TS focuses on this thought, he often cannot inhibit exactly that which he wishes most to inhibit. Since coping with this problem is very difficult, people with TS will often try to avoid those situations (such as quiet places) where they know their tics will become worse. Minimizing the importance of NOT doing something . . . or not requiring inhibition of a noise or behavior . . . can be an important therapeutic tool.

The counselor who is aware that stress makes tics worse will try to build the client's capability to better cope with stress. Stress does not have to be negative; any type of general excitement can cause tic exacer-

bation. Many families report that tics will get worse at the beginning of the school year, around Christmas time, birthdays, etc.

Sensitivity to the environment is another major problem. According to Donald J. Cohen, M.D., Director of the Yale Child Study Center and a leading TS researcher, "Many TS patients experience internal and external stimuli more vividly than non-afflicted individuals. For example, patients may be more disturbed by loud sounds or bright lights, more sensitive to touch or the feel of clothing, more distracted by events, more easily frustrated, more quick to show angry or affectionate feelings. Patients will sometimes recognize their vulnerability to become angry only after they have been adequately treated with medication and can recognize what it feels like to not be so easily angered. In short, sexual expletives, anger, irritability, and attentional and personality problems in Tourette's Syndrome all reflect an underlying psychobiological dysfunction which may involve processes of behavioral inhibition. However, much more remains to be learned about this fascinating and often debilitating disorder."

It is important to remember that not all people with TS will have these behavioral problems, and some are exemplary in school, family, and social areas. However, the TS client and family who seek the help of mental health professionals will often be burdened by behavioral abnormalities which they do not understand and have difficulty coping with. Indeed, it is important to let the family know that they should not interpret all of a child's actions as aggressive or anti-social acts. It sometimes helps for them to understand, for example, that all teenagers have many sexual thoughts, but that teenagers with TS sometimes have difficulty inhibiting those "normal" thoughts. Medication may help the inhibitory processes, but if the thoughts become inappropriate, the counselor must treat the underlying thought processes as they would any other client who does not have TS.

In short, psychotherapy can be a valuable therapeutic tool for TS clients IF the practitioner doesn't try to treat the tics, but rather the *person* who has tics.

VI. SUMMARY

Tourette Syndrome can affect just about every area of one's life. The most important factor of adjustment is early diagnosis. The longer a person with TS must endure the thought that he has these uncontrollable symptoms for no apparent reason, the more reason he has to believe that he is "crazy." Your familiarity with TS symptomatology today may result in the diagnosis of other clients in the future.

However, diagnosis and medication alone cannot eliminate all TS related problems. Many clients seeking proper diagnosis and medication enter the physician's office with the hope that diagnosis may solve ALL of their difficulties. Needless to say, months later they often become disappointed and angry. At that time people with TS often seek out assistance from non-medical service providers. The Tourette Syndrome Association is available to help you to help them.

For further information contact:

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